1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the fu... director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DMS ... Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1108 MEDICAL EXAMINER'S CERTIFICATE OF DEATH (1093)

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Patuxent River
c. LENGTH OF STAY IN 1b: 18 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): USNAS, Station Hospital Patuxent River, Maryland

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Patuxent River
d. STREET ADDRESS: USNAS 911-B MOQ
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Augustus — Last: BACAS

4. DATE OF DEATH: Month: January — Day: 11 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-9-26

9. AGE (In years last birthday): 34 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aviator

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gust "K" BACAS

14. MOTHER'S MAIDEN NAME: Helen COUTSEMARE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes 6-6-47 to 1-11-61

16. SOCIAL SECURITY NO.: 061-18-1181

17. INFORMANT: Official U.S. Marine Corp Records USNAS, Patuxent River, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): INJURIES MULTIPLE EXTREME (8651) — INTERVAL BETWEEN ONSET AND DEATH: Immediate

86 OX

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Aircraft Accident

20c. TIME OF INJURY Hour: 03:40 p.m. — Month, Day, Year: January 11 1961

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, office bldg., etc.): USNAS

20f. (City or town): USNAS, Patuxent River, Md.

(County): St. Mary's

(State): PATUXENT RIVER, MARYLAND

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural ceuses ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Stanley D Harmon — STANLEY D. HARMON LT MC USN, USNAS, Patuxent River, Maryland M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 1-11-61

EXAMINER'S NAME (Type): Wm. D. BOYD M.D. — Wm. D. Boyd MD

Address (Street, city, town, or county): Leonardtown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/16/61

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or country) (State): Arlington, Virginia

23. FUNERAL DIRECTOR — ADDRESS: P.B. Robinson - Leonardtown, Md.

24a. REC'D BY REGISTRAR DATE: JAN 16 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1107

CERTIFICATE OF DEATH

1094

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Beechville Rural
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gladys Middle: Marie Last: Ball

4. DATE OF DEATH: Month: January Day: 8, Year: 1961

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 23, 1909

9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Columbus Butler

14. MOTHER'S MAIDEN NAME: Theresa Barnes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Ellis E. Ball Address: Beechville, Maryland

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RESPIRATORY ARREST — INTERVAL BETWEEN ONSET AND DEATH: MINUTES
DUE TO (b): INTERCRANIAL HEMORRHAGE — DAYS
DUE TO (c): HYPERTENSIVE CARDIO-VASCULAR DE. — YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [redacted] 1/6 1961, to 1/8, 1961, that (I) (we) last saw the deceased alive on 1/8 1961, and that death occurred at 5:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James R. Jarboe M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): James Jarboe M. D.

22d. ADDRESS: Great Mills, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/11/61

23c. NAME OF CEMETERY OR CREMATORY: St. Peter Claver

23d. LOCATION (City, town, or county) (State): Ridge, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 11 '61

25b. REGISTRAR'S SIGNATURE: Evelyn L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1108

CERTIFICATE OF DEATH

1095

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Valley Lee
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Joseph Last: Buckley

4. DATE OF DEATH: Month: January Day: 1, Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 1, 1920

9. AGE (In years last birthday): 40 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW11

16. SOCIAL SECURITY NO.: 219 16 1244

17. INFORMANT: Ethel Buckley Address: Valley Lee, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL Embolus — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): MYOCARDIAL INFARCTION — days.
DUE TO (c): ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — YEARS

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Alcoholism

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/15, 1960 to 1/1, 1961, that (I) (we) last saw the deceased alive on 1/1 1961, and that death occurred at 3:55 M, from the causes and on the date stated above.

22a. SIGNATURE: James P. Jarboe M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/3/61

22c. PHYSICIAN'S NAME (Type): JAMES R. JARBOE, M.D

22d. ADDRESS: GREAT MILLS, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-4-61

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town, or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 4 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the items are unknown, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1109 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 1096

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chaptico
c. LENGTH OF STAY IN 1b: 15 mins.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Chaptico
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
John	Allen	Bush	January	27,	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Colored		January 27, 1961					15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Janes Douglas Butler	Alice Cecelia Bush

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
		Miss Alice C. Bush Chaptico, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Premature	15 mins
DUE TO (b)		
DUE TO (c)		

776 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

ACTUAL SIGNATURE: Wm D Boyd M.D. M.D.

EXAMINER'S NAME (Type): William D. Boyd M. D.

Address (Street, city, town, or county):

DATE SIGNED: 1/28/61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	1/28/61	St. George's Cemetery	Valley Lee, Md.

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
W.Clarke Mattingley Leonardtown, Maryland	FEB 1 '61	Arthur S. Kraus

400141 XVI

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1110

1027

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1. **PLACE OF DEATH**
   a. COUNTY: St. Mary's — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
   c. LENGTH OF STAY IN 1b: 4 days
   d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Mary's Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: St. Mary's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Hollywood
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Mildred — Middle: — Last: Carter

4. **DATE OF DEATH**: Month: January — Day: 16, — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 8, 1896

9. AGE (In years last birthday): 65 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Kendrick

14. MOTHER'S MAIDEN NAME: Effie McCathron

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: Ralph A. Carter Address: Hollywood, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Mitral Stenosis — 5 years
DUE TO (c):

410 X
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 3 1961 to Jan 16 1961, that (I) (we) last saw the deceased alive on Jan 16 1961, and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: P. J. Bean M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Jan 18 1961

22c. PHYSICIAN'S NAME (Type): P. J. Bean M. D.

22d. ADDRESS: Great Mills, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-19-61

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town, or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 23 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1111

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: St. Marys — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Marys Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Marys
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Inigoes
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henrietta — Middle: - — Last: Chisley

4. DATE OF DEATH: Month: January — Day: 1, — Year: 19 61

5. SEX: female — 6. COLOR OR RACE: colored — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: Sept. 15, 1894 — 9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John H. Medley
14. MOTHER'S MAIDEN NAME: Kattie Washington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: -----
17. INFORMANT: Edward T. Chisley — Address: St.Inigoes, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

DUE TO (b): Generalized arterial sclerosis — 4 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/ 11 1959, to Jan. 1, 1961, that (I) (we) last saw the deceased alive on Dec. 28 1960, and that death occurred at 4 A.M. from the causes and on the date stated above.

22a. SIGNATURE: P.J. Bean M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 1/1/61
22c. PHYSICIAN'S NAME (Type): P.J. Bean, MD
22d. ADDRESS: Great Mills, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1/4/61 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion — 23d. LOCATION (City, town, or county) (State): St. Inigoes, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: P.B. Robinson — ADDRESS: P.B. Robinson - Leonardtown, Md.
25a. REC'D BY REGISTRAR — DATE: JAN 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Harris

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

Item 18 Film 281 2-14-61 ens

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1112 MEDICAL EXAMINER'S CERTIFICATE OF DEATH (1093)

Item 13 Film 279 1-31-61 et

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: St. Mary's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Lexington Park
   c. LENGTH OF STAY IN 1b: 1 yr 5 mo
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 29 Roosevelt Ave

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: St. Mary's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lexington Park
   d. STREET ADDRESS: 29 Roosevelt Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Winfred — Middle Anthony — Last ELLIOTT

4. DATE OF DEATH: Month Jan. — Day 6 — Year 1961

5. SEX: Male

6. COLOR OR RACE: Negroid

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8 Feb. 1929

9. AGE (In years last birthday): 31 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (Deceased) Anselm Elliott

14. MOTHER'S MAIDEN NAME: Carrie CHEATAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): Yes 6/4/46-1/6/61

16. SOCIAL SECURITY NO.: 179-22-7631

17. INFORMANT: Official U.S. Navy Records — Address: NAS., Patuxent River, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Strangulation — INTERVAL BETWEEN ONSET AND DEATH

974X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hanging

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.): Suicide - hung himself

20c. TIME OF INJURY Hour XX p.m. Month, Day, Year: 6:15 Jan 6 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Lexington Park (County) St. Mary's (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: P. J. Bean M.D.

EXAMINER'S NAME (Type): P. J. BEAN

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 1-6-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Transportation

22b. DATE THEREOF: 1/8/61

22c. NAME OF CEMETERY OR CREMATORY:

22d. LOCATION (City, town, or country) (State): Braddock, Pennsylvania

23. FUNERAL DIRECTOR: P.B. Robinson

ADDRESS: P.B. Robinson - Leonardtown, Md.

24a. REC'D BY REGISTRAR: DATE JAN 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1131

1. PLACE OF DEATH
a. COUNTY St. Mary's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River
c. LENGTH OF STAY IN 1b 14 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USNAS, Station Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) U.S. Naval Air Station
d. STREET ADDRESS BOQ Patuxent River, Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: William Middle: Aeden Last: Fitzpatrick
4. DATE OF DEATH Month: January Day: 11 Year: 1961

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 14 August 1926
9. AGE (In years last birthday): 34 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aviator
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy
11. BIRTHPLACE (State or foreign country): Connecticut
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter Thomas FITZPATRICK
14. MOTHER'S MAIDEN NAME: Dorthy MABRAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 9-12-44 1-11-61
16. SOCIAL SECURITY NO.: 425 32 4520
17. INFORMANT: Official U.S. Naval Records, USNAS, Patuxent River, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): FRACTURE, COMPOUND, n.e.c. SKULL, Basal, With — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs 45 Min

860 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Artery And Nerve Involvement (8020)
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20e. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Aircraft Accident
20c. TIME OF INJURY Hour: 1825 e.m. p.m. Month, Day, Year: 11 Jan. 1961
20d. INJURY OCCURRED While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): USNAS, Patuxent River, Maryland
20f. (City or town) (County) (State): USNAS, Patuxent River, Md. St. Mary's

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Stanley D. Harmon — Stanley D. HARMON LT MC USN, USNAS, Patuxent River, Maryland — M.D.
CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Wm. D. Boyd M.D.
Address (Street, city, town, or county): Leonardtown, Maryland
DATE SIGNED: 1-11-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 1/13/61
22c. NAME OF CEMETERY OR CREMATORY:
22d. LOCATION (City, town, or country) (State): Texarkana, Texas

23. FUNERAL DIRECTOR: P.B. Robinson — ADDRESS: P.B. Robinson - Leonardtown, Md.
24a. REC'D BY REGISTRAR DATE: JAN 16 '61
24b. REGISTRAR'S SIGNATURE: Clarence L. Graves

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1113

CERTIFICATE OF DEATH

(1161

1. PLACE OF DEATH
a. COUNTY: St. Marys — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Marys

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mechanicsville

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Marys Hospital

d. STREET ADDRESS: Rural

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Jane — Last: Gray

4. DATE OF DEATH: Month: January — Day: 25 — Year: 19 61

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ? ? 1879

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Sallie A. Russell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): -----

16. SOCIAL SECURITY NO.: -----

17. INFORMANT — Address: Mary T. Hayden - Mechanicsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 Years

DUE TO

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 22 1961 to Jan 25 1961, that (I) (we) last saw the deceased alive on Jan 25 1961, and that death occurred at 7.7 M, from the causes and on the date stated above.

22a. SIGNATURE: P.J. Bean M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/27/61

22c. PHYSICIAN'S NAME (Type): P.J. Bean, MD.

22d. ADDRESS: Great Mills, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/30/61

23c. NAME OF CEMETERY OR CREMATORY: St. Joseph Cemetery

23d. LOCATION (City, town, or county) (State): Morganza, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: P.B. Robinson

ADDRESS: P.B. Robinson - Leonardtown, Md.

25a. REC'D BY REGISTRAR — DATE: FEB 1 '61

25b. REGISTRAR'S SIGNATURE: Conrad L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1114

CERTIFICATE OF DEATH

C1162

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: St. Mary's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Morganza
   c. LENGTH OF STAY IN 1b: 20 yrs
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: St. Mary's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural — Morganza
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: William — Middle: A. — Last: Herbert

4. **DATE OF DEATH**: Month: Jan. — Day: 20 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Sept. 3, 1890

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Herbert

14. MOTHER'S MAIDEN NAME: Maria L.Cutch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW1

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary F. Herbert — Address: Morganza, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis & Hemp Cy.
DUE TO (b): Hypertension & Arteriosclerosis
DUE TO (c): Cerebral Hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gangrene of Toe

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct. 19[illegible], to Jan. 19[illegible], that (I) (we) last saw the deceased alive on Jan. 19[illegible], and that death occured at [illegible]M, from the causes and on the date stated above.

22a. SIGNATURE: David L. Mossman M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 1-22-61

22c. PHYSICIAN'S NAME (Type): David L. Mossman M.D.

22d. ADDRESS: Mechanicsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/24/61

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Va.

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: W. Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Harris

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH (1103

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Piney Point
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Piney Point
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Patrick	William	Jordon	January	28,	19 61

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Colored		Sept. 29, 1960		3	30		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jerry Joseph Jordon	Marlene Edith Briscoe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
		Mother same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
493 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

ACTUAL SIGNATURE: Wm D Boyd M.D. — DATE SIGNED

EXAMINER'S NAME (Type): William D. Boyd M. D. — Address (Street, city, town, or county): 1/28/61

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
Burial	1/29/61	St. George Cemetery	Valley Lee, Maryland

23. FUNERAL DIRECTOR ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
W.Clarke Mattingley Leonardtown, Maryland	FEB 1 '61	Arthur S. Trump

2078309XV6

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1116 C1104

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 8 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Clements
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Brenda — Middle Eileen — Last Lacey

4. DATE OF DEATH: Month January — Day 13, — Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 31, 1960

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR — Months 2 — Days 13 — IF UNDER 24 HRS. — Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Gilbert Lacey

14. MOTHER'S MAIDEN NAME: Agnes Anita Bowles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mother — Address: same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 057.0 — DUE TO: Meningitis, Septicemia - Meningococcal
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) — DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/13/61 19___ to 1/13/61 19___, that (I) (we) last saw the deceased alive on 1/13/61 19___, and that death occurred at 3 P. M. from the causes and on the date stated above.

22a. SIGNATURE: Joseph E Gill M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/14/61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1-15-61 — 23c. NAME OF CEMETERY OR ~~CREMATORY~~: Sacred Heart — 23d. LOCATION (City, town, or county) (State): Bushwood Md

24. FUNERAL DIRECTOR'S SIGNATURE: McClarke Mattingly — ADDRESS: Leonardtown, Md

25a. REC'D BY REGISTRAR DATE: JAN 17 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

2078256 x V 7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be affixed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1117 (1105

1. PLACE OF DEATH
a. COUNTY: St. Marys — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: St. Marys Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Marys
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): X Hollywood
d. STREET ADDRESS: 1 Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis — Middle: Wayne — Last: Norris

4. DATE OF DEATH: Month: January — Day: 8 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/24/1959

9. AGE (In years last birthday): 1 yrs. — IF UNDER 1 YEAR: Months: 2, Days: — IF UNDER 24 HRS.: Hours: —, Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis Meidzinski

14. MOTHER'S MAIDEN NAME: Mary Louise Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): --- (If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: -----

17. INFORMANT — Address: Mary L. Norris - Hollywood, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, bronchial — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b):
DUE TO
(c):

4 91X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hydrocephalus + Congenital brain defect

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospitol) attended the deceased from ____ 19___ , to ____ 19___ , thot (I) (we) last saw the deceased alive on ____ 19___ , and thot death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: J. Roy Guyther M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 1/9/61

22c. PHYSICIAN'S NAME (Type): J. Roy Guyther, MD

22d. ADDRESS: Mechanicsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 1/10/61 — 23c. NAME OF CEMETERY OR CREMATORY: St. Johns Cemetery — 23d. LOCATION (City, town, or county) (State): Hollywood, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: P.B. Robinson - Leonardtown, Maryland

25a. REC'D BY REGISTRAR — DATE: JAN 12 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

Items 18-21 Film 282
3-8-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1118 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(1116)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any item is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH
a. COUNTY: St. Marys — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Hollywood
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Rural

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Marys
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hollywood
d. STREET ADDRESS: 1 Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BARTON Middle KENDALL Last PAYNE

4. DATE OF DEATH: Month January Day 29 Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3/30/1959

9. AGE (In years last birthday): 1 yrs. IF UNDER 1 YEAR: Months 10 Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles C. Payne

14. MOTHER'S MAIDEN NAME: Ola V. Sparks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give wer or dates of service): -----

16. SOCIAL SECURITY NO.: -------

17. INFORMANT Address: Chas. C. Payne - Hollywood, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH:
491X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Malformation of the Brain and Traumatic Brain Damage

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Probable fall

20c. TIME OF INJURY Hour a.m. p.m. ? Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Hollywood (County) St. Marys (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)
DATE SIGNED: 1/29/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/1/61

22c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cem.

22d. LOCATION (City, town, or country) (State): Great Mills, Md.

23. FUNERAL DIRECTOR: P.S. Robinson

ADDRESS: Leonardtown, Md.

24a. REC'D BY REGISTRAR DATE FEB 2 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1119

CERTIFICATE OF DEATH

C1107

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1. PLACE OF DEATH — a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Mechanicsville
c. LENGTH OF STAY IN 1b: 30 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: St. Mart's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rt. 2 Box 148 Mechanicsville,
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Wm. HOWARD — Middle: — Last: Redmond
4. DATE OF DEATH: Month: January — Day: 22, — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Feb. 1, 1885
9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: William Redmond
14. MOTHER'S MAIDEN NAME: Sarah F. Nalls
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Minnie H.Redmond — Address: same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:
163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ater lung a Nasopharynx — 2 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Oct 19 61 to Jan 19 61, that (I) (we) last saw the deceased alive on 1/22 19 61, and that death occurred at [ ] M, from the causes and on the date stated above.

22a. SIGNATURE: David L Mossman M.D.
22b. DATE SIGNED
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. PHYSICIAN'S NAME (Type): David L. Mossman M. D.
22d. ADDRESS: XXXXXXXXX Mechanicsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/ 25/ 61
23c. NAME OF CEMETERY OR CREMATORY: Christ Church Cemetery
23d. LOCATION (City, town, or county) (State): Arlington, Chaptico, XX. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: W.C larke Mattingley — ADDRESS: Leonardtown, Maryland

25a. REC'D BY REGISTRAR — DATE: JAN 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Hamm

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1120

CERTIFICATE OF DEATH

(1108

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b: 5days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Mary's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institutian: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Hollywood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Leonard — Middle Cecil — Last Russell

4. DATE OF DEATH: Month January — Day 11, — Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 5, 1890
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Md. State Road Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Enders Stephen Russell
14. MOTHER'S MAIDEN NAME: Alice Ann Cecil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220 36 9424A
17. INFORMANT: Mrs Mae B. Russell — Address: Hollywood, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Cardiac dilatation — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Chronic myocarditis and Asthma (Chronic)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.2
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/10 1960 to 1/11 1961, that (I) (we) last saw the deceased alive on 1/10 1961, and that death occurred at 5:10AM from the causes and on the date stated above.

22a. SIGNATURE: Charles Greenwell M.D. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Charles Greenwell M. D.
22d. ADDRESS: Leonardtown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/14/61
23c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery
23d. LOCATION (City, town, or county) (State): Hollywood, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: W.Clarke Mattingley Leonardtown, Maryland
25a. REC'D BY REGISTRAR DATE: JAN 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Forrest

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1121

CERTIFICATE OF DEATH

Reg. Dist. No. 1169

1. PLACE OF DEATH
a. COUNTY: St. Marys — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Marys Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Marys
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hollywood
d. STREET ADDRESS: 1 Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bernard; Middle: James; Last: Somerville

4. DATE OF DEATH: Month: January; Day: 30; Year: 1961

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/21/1902

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman

10b. KIND OF BUSINESS OR INDUSTRY: Sea Food

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Somerville

14. MOTHER'S MAIDEN NAME: Alice Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: -----

17. INFORMANT: Mary S. Somerville, Address: Hollywood, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr
DUE TO (b): Arterio-sclerotic cvdis — 5 yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Heather Sullivan

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1961, to Jan 30, 1961, that I last saw the deceased alive on Jan 29, 1961, and that death occurred at 6:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Roy Guyther, M.D. — ADDRESS (Street, city or town, state): Mechanicsville Md — DATE SIGNED: 1/30/61

PHYSICIAN'S NAME (Type): J. Roy Guyther, MD — Mechanicsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/2/61
22c. NAME OF CEMETERY OR CREMATORY: St. Johns
22d. LOCATION (City, town, or county) (State): Hollywood, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: T. B. Robinson
ADDRESS: T.B. Robinson - Leonardtown, Md.

24a. REC'D BY REGISTRAR DATE: FEB 2 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Knaus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1122

CERTIFICATE OF DEATH

C1116

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
   a. COUNTY: St. Mary's — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Leonardtown,
   c. LENGTH OF STAY IN 1b: 2 days
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress): St. Mary's Hospital

2. **USUAL RESIDENCE** (Whare deceesed livad, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: St. Mary's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town): Rural Helen
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Patsey — Middle: Elaine — Last: Wathen

4. **DATE OF DEATH**: Month: January — Dey: 29, — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Aug. 5, 1960

9. AGE (In yeers last birthday) yrs.: IF UNDER 1 YEAR Months: 5 Deys: 23 — IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John A. Wathen

14. MOTHER'S MAIDEN NAME: Catherine P. Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or detes of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mother — same as # 2 above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one ceuse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, Lobar,
DUE TO (b):
Conditions, if eny, which geve rise to immediete ceuse (a), steting the underlying ceusa lest. DUE TO (c):
490X

INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter natura of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Dey, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occured at.....M, from the causes and on the date stated above.

22a. SIGNATURE: Roy Gunther M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Mechanicsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/31/61

23c. NAME OF CEMETERY OR CREMATORY: St. Joseph's

23d. LOCATION (City, town or county) (State): Morganza, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W.Clarke Mattingley Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

2078246 X V 5

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1128 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6111

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any item is unknown, please write "unknown" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: St. Mary's — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Patuxent River
c. LENGTH OF STAY IN 1b: 35 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): USNAS, Station Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lexington Park
d. STREET ADDRESS: 107 Beechwood Place, Town Creek Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Francis — Middle: — Last: WHALEN Jr.

4. DATE OF DEATH: Month: January — Day: 3 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10 February 1924

9. AGE (In years last birthday): 36 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aviator

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Francis WHALEN

14. MOTHER'S MAIDEN NAME: Lena D. MEEKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): YES 7-2-42 to 1-3-61

16. SOCIAL SECURITY NO.: 191 18 0161

17. INFORMANT: Official U.S. Navy Records — Address: USNAS, Patuxent River, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 860X INJURIES, MULTIPLE, EXTREME (8651) — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.): Aircraft Accident

20c. TIME OF INJURY Hour: 1:06 p.m. — Month, Day, Year: 3 January, 61

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): USNAS, Patuxent River, Maryland

20f. (City or town) (County) (State): USNAS, Patuxent River, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: STANLEY D. HARMON LT MC USN, M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 1-3-61

EXAMINER'S NAME (Type): Wm. D. BOYD M.D.

Address (Street, city, town, or county): Leonardtown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/6/61

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or country) (State): Arlington, Va.

23. FUNERAL DIRECTOR: P.B. Robinson — ADDRESS: Leonardtown, Md.

24a. REC'D BY REGISTRAR — DATE: JAN 9 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VS. A15ME
5M 7/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any item is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of VITAL STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1124 — C 112

1. PLACE OF DEATH
a. COUNTY: St. Marys — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Leonardtown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): St. Marys Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: St. Marys
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Great Mills
d. STREET ADDRESS: / Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: CLAUD — Middle: SWANSON — Last: WILBURN

4. DATE OF DEATH: Month: January — Day: 16 — Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 29, 1907

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Weapons Test

10b. KIND OF BUSINESS OR INDUSTRY: Civil Service

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Asa V. Wilburn

14. MOTHER'S MAIDEN NAME: Elizabeth S. Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give were or dates of service): ----

16. SOCIAL SECURITY NO.: 578 16 9540

17. INFORMANT — Address: Maude E. Wilburn- Great Mills, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease. — INTERVAL BETWEEN ONSET AND DEATH:
422.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Operative Exploration of Right Shoulder.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Therapeutic Misadventure.

20c. TIME OF INJURY Hour XXX p.m. — Month, Day, Year: 1/16 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hospital

20f. (City or town) (County) (State): Leonardtown St. Mary's Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S Petty M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 1/17/61

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/21/61

22c. NAME OF CEMETERY OR CREMATORY: Republician Grove Cem.

22d. LOCATION (City, town, or country) (State): South Boston, Virginia

23. FUNERAL DIRECTOR: P.B. Robinson - Leonardtown, Md.

ADDRESS

24a. REC'D BY REGISTRAR DATE: JAN 24 '61

24b. REGISTRAR'S SIGNATURE: Cutting S. Hayes